A MANUAL OF ORGANIC MATERIA MEDICA, BEING A GUIDE TO MATERIA MEDICA OF THE VEGETABLE AND ANIMAL KINGDOMS, FOR THE USE OF STUDENTS, DRUGGISTS, PHARMACISTS, AND PHYSICIANS. By JOHN M. MAISCH, Ph.M., Phar.D. Seventh edition, revised by HENRY C. C. MAISCH, Ph.G., Ph.D. Pp. 523, with 285 illustrations. Philadelphia and New York: Lea Brothers & Co., 1899.

MATERIA MEDICA AND THERAPEUTICS, AN INTRODUCTION TO THE RATIONAL TREATMENT OF DISEASE. By J. MITCHELL BRUCE. M.D. Pp. 609. Philadelphia and New York: Lea Brothers & Co., 1899.

THIS standard work of the late Dr. Maisch has been revised by his son, as the advance of pharmaceutical knowledge allows and the alterations in the British *Pharmacopœia* render necessary. Despite its title-page, the book is evidently intended even more for the pharmacist than the physician. It contains, however, a vast number of facts given in a concise form regarding those substances which furnish our drugs. The large number of excellent illustrations which accompany the verbal descriptions materially enhance the value of the book.

Dr. Bruce's book consists of essentially two parts—a consideration of the drugs official in the British *Pharmacopœia* and a study of the various organs of the body from a therapeutical stand-point.

The first part of the book is devoted to a description of the various medicinal substances, with brief notes of their physiological action and therapeutic uses. In the pharmaceutical portion we find concisely and intelligently arranged much valuable information about such points as the source, solubility, impurities, and incompatibilities of the drugs treated of—things that are oftentimes difficult or wellnigh impossible to find without searching several books.

The therapeutical portion of the book is not nearly so fortunately arranged. When an author undertakes, as in the present instance, to consider in the space of a couple of hundred pages all of physiology, pathology, and therapeutics he would seem to be almost courting disaster. It is no wonder, then, to find that the subject has in many instances been so condensed as to be contradictory and almost unintelligible. Thus, for instance, alcohol is said to stimulate the bloodvessels both centrally and peripherally, while lower down on the same page it is classed among the vaso-dilators. Also, we find several inaccuracies (some of which seem to be from lack of care in the revision of the present edition), such as the statement that the vaso-constrictor influence of ergot is a peripheral one, or that the action of opium on the pars vagum is principally a depressant one. Many disputed questions, such as the action of alcohol on the metabolism of the body and the mode by which iron increases the hæmoglobin the author seems to consider as settled beyond all cavil, wherein he differs from many who are accepted as authorities.

Of course, such errors render the book to a large extent unfit for students, while its brevity impairs its value as a therapeutic work of reference. The portion on materia medica, however, will frequently give a ready answer to those questions which so often arise regarding this subject.

H. C. W., JR.

PROGRESS
OF
MEDICAL SCIENCE.

MEDICINE.

UNDER THE CHARGE OF
WILLIAM OSLER, M.D.,
PROFESSOR OF MEDICINE IN THE JOHNS HOPKINS UNIVERSITY, BALTIMORE, MARYLAND,
AND
GEORGE DOCK, M.D.,
PROFESSOR OF MEDICINE IN THE UNIVERSITY OF MICHIGAN.

Rashes After Enemata.—Monro calls attention again to the not infrequent association of cutaneous rashes with the administration of rectal enemata. Text-books on dermatology rarely make mention of the condition. The writer thinks that many rashes attributed to surgical operations or to an anæsthetic are in reality enema rashes. He believes that some cases of so-called surgical and puerperal scarlatina are instances of scarlet rash due to enemata. The possibility of the eruption being caused by the administration of drugs can, in the majority of instances, be eliminated.

The recorded cases are confined to the English language, and, with one exception, to British literature. The enema rash is much more common in females than in males. One case has been reported in a boy, aged eleven years; all the other published cases, twenty-six in number, were in females. Monro's six cases, which he reports, were also in females. Habitual constipation, whether primary or secondary to gastric disorders, seems to be a predisposing factor, and probably explains the preponderance of the rash in the female sex. The patients are generally adults, although the rash has been observed in childhood.

The interval that elapses between the giving of the injection and the appearance of the eruption is usually about twelve hours. It may be more than twenty-four or as short as two hours. The rash generally lasts two or three days; but the duration may be twenty-four hours or less, or it may be four days.

According to Monro, three principal types of the eruption may be distinguished—the scarlatiniform, the measley, and the small-whealed urticarial. Two or all of these may be present in one individual. The first variety is specially important, because of the liability of its being mistaken for true scarlet fever, and the third because of the severe itching with which it may be associated. Moorhouse has observed a rash maintain the urticarial type for twenty-four hours, then to become scarlatiniform for a few hours, and later to revert to the original type.

The distribution varies, and is not always symmetrical. The buttocks and thighs, and after these the face, may be considered the seats of predilection. The rash, however, may involve all parts of the body. There is usually no associated pyrexia. Occasionally a temperature of 101° to 102° has been observed. It may be associated with a severe burning sensation and intense itching. Coupland observed a case in which desquamation occurred after the rash had been out for three days. Desquamation is rare, however.

The urine remains free from albumin. Staveley states that indican can be detected in the urine, whereas it is rare in the early stages of scarlet fever.

Monro states that the rash occurs only after bulky injections, and never, so far as he is aware, after glycerin or nutrient enemata.

The explanation generally given for the occurrence of the rash is that it is due to fecal absorption. The large quantity of water dissolves some of the solid contents of the bowel, and as a result a considerable quantity of excrementitious matter is rapidly absorbed. This, being partly excreted by the skin, gives rise to the rash. Morgan, on the other hand, suggested in 1895 that the cutaneous lesion resulted from the use of a particular kind of soap in the enema. This view was supported by Gardner, who observed a considerable number of cases after the use of hard, yellow soap, whereas he has met with no rash in four hundred cases where soft soap was employed. He believed that the particular variety of soap was the main factor in the production of the rash. He found that the hard soap contained a trace of iron and was very slightly alkaline in reaction.

Monro raises some objections to the soap theory, but asserts that experience has shown that soft and not hard soap should be used for enemata. He gives detailed notes of six cases of enema rashes which came under his own observation.—*The Glasgow Medical Journal*, September, 1899, p. 165.

A Case of Acute Suppurative Cholecystitis, with Isolation of the Bacillus Typhosus, Eighteen Years After an Attack of Typhoid Fever.—HUNNER reports a case of acute suppurative cholecystitis due to the bacillus typhosus, which again illustrates the importance of this organism in the causation of gall-bladder infections and also the great length of time it may persist in the system after typhoid fever before setting up local inflammations.

A German woman, aged fifty-four years, was admitted to the Johns Hopkins Hospital on February 3, 1899. She gave a history of an attack of "remittent fever" eighteen years ago. She remained in bed only two weeks, and then insisted on getting up, although her illness continued for two months. There was typhoid fever in the neighborhood at the time. Three and one-half years before admission the patient was ill for a period of six weeks. The illness began with sudden onset of pain in the right side, shooting down into the right inguinal region. The attacks were intermittent in character, lasting half an hour or more and causing much nausea and abdominal tenderness. For two years she had slight pains and tenderness in the right side. Eighteen months before admission the attacks of pain increased in frequency and severity, and frequently after a paroxysm she could not bear the weight of her clothing. These attacks were apparently of gall-bladder origin.

Two years before entering the hospital she noticed a small, movable mass in the lower right quadrant of the abdomen.

The patient was operated on by Dr. Kelly after admission to the hospital. A large cyst was found springing from the region of the left ovary, and the right ovary was represented by a hard mass the size of a fist. Both ovaries and tubes and an adherent appendix were removed. Convalescence from operation was without interest until the fourteenth day, when she complained of nausea, and vomited several times. On the sixteenth day she had an attack similar to those complained of during the previous three and a half years. At the right costal margin a sensitive tumor, which was dull on percussion, could be palpated. The temperature was 101° F. On the following day the pulse was 140 per minute and the temperature was 103° F. A visible tumor, extremely tender, protruded in the right hypochondrium. The leucocytes were 29,009.

The condition was believed to be either a localized abscess following the removal of the appendix or an acute cholecystitis. Dr. Stokes operated and found a greatly distended and congested gall-bladder. There were fresh adhesions about the gall-bladder and a sero-fibrinous exudate in the peritoneal cavity. Cholecystotomy was performed and the gall-bladder permanently drained. No stone was found at the operation, but a calculus the size of a pea was discharged one week later.

In brief, the cultures from the gall-bladder gave a pure growth of a bacillus which corresponded in all its cultural characteristics with the bacillus typhosus. The bacillus, on certain media, presented many involution forms, with peculiar staining properties. The patient's own blood-serum agglutinated the organism in dilutions of 1 : 10 and 1 : 40. Her serum gave a positive Widal with a known typhoid organism in dilutions up to 1 : 100. The organism was pathogenic to rabbits.

Cushing, one year ago, collected four cases of typhoidal cholecystitis with gallstones, and reported two new cases. About the same time other cases were reported by Imhofer, Miller, and Mixter, so that, with Hunner's case, there are now ten authenticated cases of typhoid cholecystitis and cholelithiasis confirmed by bacteriological examination.

Cushing proposed the following theory regarding the gallstone formation in cases of typhoidal cholelithiasis: (1) The bacilli during the course of typhoidal infection quite constantly invade the gall-bladder; (2) the organisms retain their vitality in this habitat for a long period; (3) in the course of time the bacilli are almost invariably found clumped in the bile, suggesting the occurrence of an intravesical agglutinative reaction; (4) the clump presumably represents nuclei for the deposit of biliary salts, as micro-organisms may with regularity be demonstrated in the centre of recently formed stones; (5) gallstones being present in association with the latent, long-lived infective agents, an inflammatory reaction in the viscus of varying intensity may be provoked at any subsequent period.

Hunner reviews the various theories relating to cholecystitis and cholelithiasis. Of especial interest is the growing belief that gallstones are in most cases of infectious origin. Naunyn first formulated this theory, and was subsequently supported by Gilbert and Mignot, in France, and Richardson and Cushing, in this country.

Mignot, after careful experiments, states that the chief factors in the production of biliary lithiasis are: (1) The presence in the gall-bladder of an attenuated organism of any variety whatever; (2) a relative inertia of the biliary reservoir, causing partial stasis and preventing the premature expulsion of soft concretions of cholesterin.—*Johns Hopkins Hospital Bulletin*, August-September, 1899, p. 163.

Œsophagitis and Phlegmonous Periœsophagitis.—The patient was unable to swallow solid food, and even fluids caused severe pain in the upper portion of the œsophagus. By the use of the sound a stricture was detected in the upper portion of the œsophagus. It was impossible at first to pass the sound beyond the stricture. Later, by using considerable pressure, it was passed into the stomach, but at times caused great pain. Four days after entering the hospital the patient felt well and had no fever. The next night marked dyspnœa suddenly developed, and in a short time the patient was dead. In the jugulum and on both sides of the neck as high as the mastoid processes there was demonstrable emphysema of the skin. Post-mortem examination showed isolated calcified tuberculous foci in both apices. Over the last cervical vertebra there was a pus-cavity which extended into the posterior mediastinum in the region of the bifurcation. The lower portion of the œsophagus was normal. At the beginning of the œsophagus the posterior wall was thickened about 1 cm. Three cm. below the larynx there was an easily dilated stricture about 2 cm. long. The œsophageal mucous membrane was entirely normal. The submucous tissue and the musculature of the lower œsophagus were normal. One cm. below the lower border of the cricoid cartilage there was a spindle-shaped, purulent, strictly submucous infiltration, 7½ cm. in length. At the level of the thyroid cartilage there was a crescent-shaped, dirty green, gelatinous mass at the beginning of the œsophagus posteriorly. This communicated below with a suppurating cavity which extended into the posterior mediastinum. The cause of this condition is not usually clear. Often there is rupture of a peri-œsophageal abscess, a suppurating gland, cricoid perichondritis, vertebral abscess, or, especially, breaking down of cheesy lymph-glands in the outermost layers of the œsophagus. Circumscribed abscesses in the wall of the œsophagus without demonstrable local causes have been found, especially in consumptives. The author believes that the cutaneous emphysema was caused by the pressure of gas, during the severe dyspnœa, from the purulent foci into the surrounding tissues and under the skin. The fact that the sounding caused great pain and the temporary attacks of dull pain along the œsophagus, and the fact that the sound met with resistance at different distances (this being dependent on the variable filling of the abscess-cavity), could have helped in the diagnosis. The presence of a submucous abscess directly under the larynx and pushing the mucous membrane forward explains why a resistance was met 18 cm. from the teeth on the first sounding. It is remarkable that the œsophagus—which was surrounded for three-quarters of its circumference by a purulent mass—was not perforated by the numerous probings. The investigations of Zenker and v. Ziemssen throw some light on this fact. They removed an entirely healthy œsophagus from a man killed by accident, and by attaching a weight of 5 kg. increased its length from 17 cm. to 24 cm. When a weight above 5 kg. was attached the musculature near the mucous membrane was torn, but the mucous membrane remained entirely uninjured. A weight of 10 kg. tore the mucous membrane.—HUISMANS, *Deutsche med. Wochenschrift*, 1899, No. 17.

SURGERY.

UNDER THE CHARGE OF

J. WILLIAM WHITE, M.D.,

PROFESSOR OF CLINICAL SURGERY IN THE UNIVERSITY OF PENNSYLVANIA; SURGEON TO THE UNIVERSITY HOSPITAL;

ASSISTED BY

ALFRED C. WOOD, M.D., AND C. L. LEONARD, M.D.,

INSTRUCTOR IN CLINICAL SURGERY, UNIVERSITY OF PENNSYLVANIA; ASSISTANT SURGEON, UNIVERSITY HOSPITAL.

ASSISTANT INSTRUCTOR IN CLINICAL SURGERY IN THE UNIVERSITY OF PENNSYLVANIA.

Lesions of the Lateral Sinus.—GANGOLPHE and PIERY (*Revue de Chirurgie*, September 10, 1899), from personal observations and the study of cases collected from the literature, arrive at the following conclusions:

1. Lesions of the lateral sinus may be produced in cases of traumatic injury of the cranium by a double mechanism; by being torn by spicules of bone or foreign bodies, and by rupture, where the fragments separate in cases of fracture.

2. These lesions of the lateral sinus give rise to the formation of clots, which collect between the dura mater and the skull. Their position and extent is determined on the one hand by the adhesion of the dura mater, and on the other by the extent to which it has been torn away by the traumatism. Frequently there coexists with this hemorrhage one into the arachnoid, a semi-fluid clot, the color of gooseberry jelly, covering that hemisphere of the brain.

3. The symptomatology of the lesions of the lateral sinus is most variable; it is far from realizing always the complete symptomatology of cerebral compression, and frequently produces, feature for feature, the picture of apoplexy from cerebral hemorrhage.

4. Not only is the diagnosis of a torn sinus almost always impossible, but frequently it does not permit one to affirm the presence of an intracranial hemorrhage from traumatism of a bloodvessel.

5. In such a case, where the diagnosis is difficult, although the only elements are an apoplectiform attack and a previous traumatism, it is necessary to act as if one were assured of the presence of an intracranial hemorrhage of traumatic origin.

6. The line of action to be pursued is the following:

a. Where the sinus is exposed the wound is tamponed through the opening in the skull after any fragments have been removed.

b. If the traumatism has not exposed the sinus, trephining should be immediately done. The trephine should be placed at the point where the